D.C. Board of Medicine

INFORMATION FOR THE MEDICAL COMMUNITY AND THE PUBLIC FROM THE D.C. BOARD OF MEDICINE

INSIDE THIS ISSUE

YOUR MAILING ADDRESS

Changing your mailing address? Send your name, mailing address, and license number to:

DC Board of Medicine
Processing Department
Address/Name Change
717 14th Street, NW
Suite 600
Washington, DC 20005

Government of the District of Columbia
Adrian M. Fenty, Mayor

June 2008

Letter from the Chair

Many physicians have called in panic upon receiving an Order to Answer, so I thought that I would take the opportunity of the Chairperson's Letter to explain what an Order to Answer (OTA) is and what physicians should do when they receive an OTA.

It is intimidating from the first glance. It is a very formal document, with your name at the top. It says "the Board hereby orders you to answer the complaint attached" and gives you 10 days to do so. And it says the Board can discipline you for not answering. I know it can evoke the impression that you have done something wrong. But all it means is that someone has sent a complaint to the Board and we need your side of the story. In D.C., and nationally, most complaints do not rise to the level of disciplinary action.

So, why the formality? Why the penalty? When I first came to the D.C. Board of Medicine, the Board would send a letter called Request for Reply to licensees upon receiving a complaint. It would ask for the physician's version of the complainant's allegations. It also stated that a licensee did not have to respond.

Frederick C. Finelli, M.D., J.D.

Although most physicians did reply to the Board's requests, many did not. If a physician didn't reply, the Board had no information other than the complainant's version. So we were pretty much forced to initiate an investigation of the doctor in order to get sufficient facts to resolve the complaint. The result was that scarce investigative resources were consumed that could have been more effectively employed had licensees been compelled to reply to complaints. Moreover, the time required for resolution of complaints was extended by the time that was required for investigations. In view of those problems, the D.C. Department of Health changed the regulations to require licensees to reply

(continued on page 2)

VERIFICATION FEE CHANGE!

Please note that the fee for license verifications has changed, effective August 2007. The new fee is thirty-four dollars ($34) per verification, payable to the 'DC Treasurer'.

Checks containing the wrong information will be returned and the verifications will not be processed.

Upcoming Board Meetings

(LAST WEDNESDAY OF THE MONTH)

JUNE 25, 2008
JULY 30, 2008

Open Session is at 9:00 a.m.

at 717 14th St., NW
10th Floor
Washington, DC 20005

Continuing Medical Education

The Board reminds all licensees that the continuing medical education (CME) requirement for renewal in 2008 is fifty (50) hours of Category I continuing education. The courses must be accredited by the Accreditation Council for Continuing Medical Education, the American Osteopathic Association, a state medical society, or the American Medical Association. The Board recommends that licensees accumulate CME credits throughout the renewal period in order to avoid last minute cramming and possible renewal issues.

Physician Profiles

Each physician is required to update his or her online Physician Profile. Sanctions will be imposed on physicians who do not report changes within 30 days. To update your profile, login to our online system at: https://app.hpla.doh.dc.gov/mylicense/

Questions? Call Antoinette Stokes at (202) 724-8799 or Alesia Henry at (202) 724-8797.

Letter from the Chair (continued)

to complaints. The Order to Answer is the vehicle that communicates the requirement to reply to a complaint.

Upon receipt of a complaint, it is first reviewed by the Board lawyer to make sure the complaint is "legally sufficient". This is not an evaluation of the veracity or reasonableness of the complaint, but merely a legal opinion as to whether the alleged behavior—if proved true—would potentially violate the law. If it is found legally sufficient, the Board will send the complaint with an Order to Answer to the licensee who is the subject of the complaint. The OTA specifies that the licensee has ten days from receipt to reply, and advises that the licensee's reply will be sent to the complainant for rebuttal. Upon receipt of a reply and a rebuttal, the Board will decide whether to investigate further, submit the issue for peer review, request preparation of charges or close the case. The OTA, per se, is not a disciplinary action or a charging document. It is merely a vehicle for fact finding.

"If you get an Order to Answer, —react, but don't overreact. It's your chance (and duty) to give your side of the story. Answer the allegations specifically and get the reply in within 10 days."

What happens if a physician does not reply to an OTA within ten days? The physician who does not reply as directed violates an order of the Board (the OTA) and is subject to disciplinary action by the Board. So a physician that fails to answer will be disciplined for not answering, even if the original complaint is closed.

What should be included in the physician's reply? The physician's reply should address the substantive issue(s) that were raised in the complaint. The reply from the physician should be in the form of a letter with copies of relevant documents enclosed. If the Board finds that the substantive issues were not adequately addressed, a second OTA will be mailed or an investigation initiated to acquire facts sufficient to determine whether a violation of the license law occurred that would warrant disciplinary action.

Remember, if you get an Order to Answer—react, but don't overreact. It's your chance (and duty) to give your side of the story. Answer the allegations specifically and get the reply in within 10 days. We will resolve it as quickly and fairly as possible.

—Frederick C. Finelli, M.D., J.D.
Chairperson
DC Board of Medicine

WHEN YOU MOVE (OR CHANGE YOUR NAME)

Licensees sometimes forget to inform the Board of Medicine when they move, or undergo a name change. If we do not have your current address, you may not receive your renewal mailing because we will send it to your address of record. All name and address changes must be submitted in writing to our office within 30 days of the change. Failure to do so may result in a $100 fine per section 16A DCMR § 3201.1 (d). Please include your name, address, Social Security number, and license number (if you know it). If you have a name change, you must also enclose a copy of your certificate of marriage, divorce decree, or court order that authorizes the change. Fax your request to (202) 727-8471 or mail your name and/or address change to: DC Board of Medicine, Attn: HRLA Processing Department, Address/Name Change, 717 14th Street, NW, Suite 600, Washington, DC 20005.

Counsel's Column

SAFE RX MANDATES FOR PHYSICIANS

By John C. Greenhaugh, Esq.
Senior Assistant Attorney General & Board Legal Advisor

In January 2008, the Council of the District of Columbia voted 7-6 to pass the "SafeRx Amendment Act of 2007." The law, which will not become effective until it passes the Congressional review period, expected to be in the middle of April, addresses several distinct areas. Assuming the Law remains in its present form, it will impact the practice of medicine in several ways.

First, pharmaceutical reps (or "detailers" as they are called) who market products in the District will be required to be licensed by the DC Board of Pharmacy. They will have to meet certain educational qualifications and adhere to a code of ethics. The legislation mandates that detailers be a graduate of a recognized institution of higher education (an exemption from the education requirement exists for those who have been detailers for at least 12 months). The Code of Ethics will be developed by the Board of Pharmacy. Additionally, detailers are forbidden to engage in deceptive or misleading marketing of a pharmaceutical product and must not use a title or designation that might lead a licensed health professional, or an employee or representative of a licensed health professional to believe that the detailer is licensed to practice medicine, nursing, dentistry, optometry, pharmacy, or other similar health occupation in the District unless the detailer currently holds such a license.

In addition to regulating detailers, SafeRx establishes an evidence-based pharmaceutical education program within the Department of Health to educate physicians and other prescribers who participate in the District of Columbia Medicaid program, and other publicly funded, contracted, or subsidized health-care programs. The course curriculum will include such subjects as the therapeutic and cost-effective utilization of pharmaceutical products, providing information to physicians about pharmaceutical product marketing practices that are intended to circumvent competition from generic drugs, other therapeutically-equivalent alternatives, or other evidence-based treatment options, and to utilize, or incorporate into the program other independent educational resources or models proven effective in promoting high-quality, evidence-based, cost-effective information regarding the effectiveness and safety of pharmaceutical products.

The District of Columbia will be the first jurisdiction to license pharmaceutical sales representatives. It is anticipated that there will be a phase-in period prior to the effective date of any licensure requirement to afford all who presently work as detailers to apply for and receive the new license.

ADDITIONAL REQUIREMENTS

CONTINUING MEDICAL EDUCATION (CME)

Further, the law mandates that physicians will need to include pharmacology training in their CME for the licensure period ending 12/31/10. The Board of Medicine will publish appropriate regulations after the effective date of the Law regarding the CME requirement, but physicians will be provided plenty of time to adjust their own training schedules to adhere to new CME requirements.

Safe RX requires that all pharmacology CME courses:

- must be evidenced-based;
- must provide physicians with information about the cost-effectiveness of pharmacological treatments; and
- must not be financially supported by any pharmaceutical company.

Again, the reader is reminded that any change to the current CME requirements will not be applicable to the renewal period beginning in the fall of 2008 for renewals effective January 1, 2009.

OFF-LABEL PRESCRIPTIONS AND INFORMED CONSENT

Finally, of particular note, physicians must obtain verbal "informed consent" from patients prior to prescribing, administering, or furnishing a prescription medication to a patient for an off-label use.

Informed consent includes the following 2 elements:

- make a reasonable effort to explain to the patient, in easily understood terms, that the medication is not within the uses approved for that medication by the FDA and
- provide the patient with information regarding the potential risks and side-effects associated with using the medication off-label.

The purpose of the informed consent provision is to ensure that physicians continue to practice good medicine. The purpose is not to try and "catch" good physicians. The support for this position may be found in the penalty section of the Act relating to a violation of the informed consent provision. As currently before Congress for review, Section 204 states "…a prescriber shall not be subject to an adverse licensure action if the Board of Medicine determines that the prescribing, administering, or furnishing of the prescription medication for the off-label use was clearly evidence-based and the common practice within the medical community."

Physicians who have questions regarding the implementation of the new law should contact the Board of Medicine. Additional information will be published in forthcoming newsletters as it becomes available.

NEW REGULATIONS REGARDING TAMPER-RESISTANT PRESCRIPTION PADS

By John C. Greenhaugh, Esq.
Senior Assistant Attorney General & Board Legal Advisor

If you write prescriptions for Medicaid eligible patients, and expect to be reimbursed by Medicaid, then take a moment to read the following.

On the following page are the new regulations effective April 1, 2008 requiring that a written prescription for any drug, including over-the-counter drugs, for a Medicaid fee for service beneficiary shall only be written on tamper resistant prescription pads as that term is defined below. For the first year, the prescription pad must meet any one of the three criteria set forth here, but beginning April 1, 2009, the prescription pad must meet all three of the criteria. See the regulation for details.

For the first year, the prescription pad must meet any one of the three criteria, but beginning April 1, 2009, the prescription pad must meet all three of the criteria.

The requirements apply whether Medicaid is the primary or secondary payor of the prescription being filled. The requirements do not apply to other means of prescribing, such as transmitting prescription orders to a pharmacy via telephone, telephone facsimile, or by an electronic prescription. The requirements also do not apply to refill prescriptions of an original written prescription that was presented to a pharmacy before April 1, 2008.

There are two other exceptions for using a tamper resistant pad that prescribers need to know about. The first is a short-term exception when there is an emergency prescription and back-up is provided within 72 hours that is compliant with the requirements. The second exception is a long-term one for prescribers who work in nursing facilities, hospitals and other institutional and clinical settings or provide specific enumerated services. See Section 1333.6 below of the regulation and 42 U.S.C.S. § 1396r-8(k)(3). (Section 1927(k)(3) of the Social Security Act) This last exception has to do with how the drug costs are bundled, and if they are included as part of the payment for certain activities, e.g. inpatient hospital services or hospice services are two examples, and are not direct reimbursement for the drug, then the costs of the drug would be covered by Medicaid even if not written on a tamper resistant pad.

NOTICE OF FINAL RULEMAKING: The Director of the Department of Health, pursuant to the authority set forth in section 19(a)(3) of the District of Columbia Pharmacist and Pharmacy Regulation Act of 1980, effective September 16, 1980, (D.C. Law 3-98; D.C. Official Code § 47-2885.18.01(a)(3)); the District of Columbia Uniform Controlled Substances Act of 1981, effective August 5, 1981, (D. C. Law 4-29; D.C. Official Code § 48-901.01); Mayor's Order 98-48, dated April 15, 1998, Section 4902 of the Fiscal Year 2002 Budget Support Act of 2001, effective October 3, 2001, (D.C. Law 14-28; D.C. Official Code § 7-731); Section 15 of the District of Columbia Drug Manufacture and Distribution Licensure Act of 1990, effective June 13, 1990, (D.C. Law 8-137; D.C. Official Code § 48-714(a)); and Mayor's Order 98-88, dated May 29, 1998; hereby gives notice of the adoption of the following amendments to Chapter 13 (Prescriptions and Distribution) of Title 22 of the District of Columbia Municipal Regulations (DCMR) in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

The purpose of the amendments is to implement the requirement under section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, effective May 25, 2007, (110 P.L. 28; 121 Stat. 112) regarding the use of tamper resistant prescription pads for written, non-electronic, prescriptions.

A notice of Proposed Rulemaking was published in the D.C. Register on December 21, 2007 at 54 DCR 012341. No comments were received from the public in connection with this Notice and no changes have been made. These final rules will be effective upon publication of this notice in the D.C. Register.

LOAN REPAYMENT PROGRAM REMINDER

The District of Columbia has established a loan repayment program for health care professionals. The program's main goal is to aid in the recruitment and retention of health care professionals to provide services to medically underserved residents. Participation will be approved on a case-by-case basis and each applicant is required, among other requirements, to:

- Be a United States Citizen.
- Be a physician who has completed post-graduate training in family practice medicine, general internal medicine, general pediatrics, obstetrics/gynecology, psychiatry or osteopathic general practice.

For more information, please contact:

Ms. Alesia Henry at
(202) 724-8797 / alesia.henry@dc.gov
of the DC Board of Medicine

or

Ms. Katina R. Green at
(202) 442-9168 / katina.evans@dc.gov
of the Community Health Administration, Primary Health Program

TAMPER-RESISTANT PRESCRIPTION PADS

CHAPTER 13 (PRESCRIPTIONS AND DISTRIBUTION)

IS AMENDED AS FOLLOWS:

A new section 1333 is added to read as follows:

1333 PRESCRIPTION REQUIREMENTS FOR MEDICAID COVERED SERVICES

1333.1 Effective April 1, 2008, a written prescription for any drug, including over-the-counter drugs, for a Medicaid fee for service beneficiary shall only be written on tamper resistant prescription pads meeting at least one of the following characteristics:

(a) The prescription pad contains one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) The prescription pad contains one or more industry-recognized features designed to prevent erasure or modification of information written on the prescription by the prescriber; or

(c) The prescription pad contains one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

1333.2 Beginning April 1, 2009, a written prescription for any drug, including over-the-counter drugs, for a Medicaid beneficiary shall only be written on tamper resistant prescription pads meeting all of the following characteristics:

(a) The prescription pad contains one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) The prescription pad contains one or more industry-recognized features designed to prevent erasure or modification of information written on the prescription by the prescriber; and

(c) The prescription pad contains one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

1333.3 The requirements of this section shall apply whether Medicaid is the primary or secondary payor of the prescription being filled.

1333.4 Prescription orders transmitted to a pharmacy via telephone, telephone facsimile, or electronic prescription order are exempt from the tamper resistant requirements set forth in §§ 1331.1 and 1333.2 of this chapter.

1333.5 The tamper resistant requirements in § 1333.1 of this chapter do not apply to refill prescriptions of an original written prescription that was presented to a pharmacy before April 1, 2008.

1333.6 The exceptions set forth under Section 1927(k)(3) of the Social Security Act (42 U.S.C.S. § 1396r-8(k)(3)) concerning nursing facilities, hospitals, and other institutional and clinical settings, shall also be an exception to the requirements of this section.

1333.7 In the event a prescription is not submitted on a tamper resistant prescription form meeting the requirements set forth in §§ 1331.1 and 1333.2, a pharmacy may fill the prescription in full as written on an emergency basis as long as the pharmacy receives a verbal, telephone facsimile, electronic, or compliant written prescription within seventy-two (72) hours after the date on which the prescription was filled.

1333.8 Effective April 1, 2008, the Medical Assistance Administration (MAA) shall only reimburse providers for covered Medicaid outpatient drugs when the written, non-electronic, prescription is executed on a tamper resistant pad meeting the requirements of this section.

Talk about PPTEP: Help Young Physicians Avoid the Burden of Administrative Fines

Please advise residents/ trainees about the Board of Medicine's mandatory Postgraduate Physician Training Enrollment Program (PPTEP), which tracks postgraduate physicians practicing in the District. This program requires annual enrollment; it is NOT a one-time enrollment, and it is not a license. The District does not issue temporary or training licenses.

RESIDENT/TRAINEE ANNUAL ENROLLMENT

1) Each year, submit a PPTEP form electronically via our website at:

www.hpla.doh.dc.gov

- Click 'Professional Licensing Boards/Registrations, then 'Medicine', then 'Postgraduate Physician Enrollment'.
- Please jot down the ID and Passwords you create the first year, so you can use them in subsequent years.

2) Then also submit the PPTEP form, printed out on paper, to the residency program Graduate Medical Education Director, along with the annual fee of $50.00. The program director will sign your form and submit the form to the Board of Medicine.

- Any 'YES' answers on the questionnaire must be accompanied by supporting documentation and explanation. Failure to do so will delay approval.
- Enrollment is not complete until the application is reviewed and approved by the DC Board of Medicine.

THOSE WHO SHOULD ENROLL IN PPTEP (do not need a full DC medical license):

• A "postgraduate physician" (as it applies in Section 4611.13 of the regulation) is a person who holds a degree in medicine or osteopathy, and who is enrolled in a postgraduate clinical program prior to licensure in any jurisdiction in the United States. *The postgraduate program must be ACGME-approved or approved by the DC Board of Medicine.*

• A foreign medical graduate (FMG) who acquired a license in another jurisdiction that requires less training than the three years required for a DC medical license is not yet eligible for a license. These foreign medical graduates will be allowed to continue to enroll as postgraduate physicians until they are eligible for a DC license.

THOSE WHO SHOULD NOT ENROLL IN PPTEP (do need a full DC medical license):

• A physician who has completed a postgraduate program, or is in the sixth year of a postgraduate training program.

• A fellow who has already completed a postgraduate training program (residency).

• Any resident/trainee that holds a full medical license (i.e. not a "training" license) in any other jurisdiction should apply for a full medical license (not enroll in PPTEP).

Failure to obtain the full DC license constitutes "practice without a license" and individual will be subject to disciplinary action.

DISCIPLINARY WAIVER

Disciplinary action will be waived for those who obtained the other license during the last 6 months of their program. These postgrads will not be fined, and may continue to the end of their program without obtaining a DC license.

THOSE WHO ARE EXEMPT FROM ENROLLING IN PPTEP

Trainees participating in short rotations of 90 days or less are exempt from enrolling.

Trainees under federal jurisdiction (i.e. the military or NIH) are exempt from enrolling in PPTEP.

Questions about the PPTEP? Call Board Licensing Specialist Lisa Robinson at (202) 724-8802

REGULATIONS FOR PRESCRIBING CONTROLLED SUBSTANCES

Below is a handy reference chart summarizing the rules for prescribing controlled substances in the District of Columbia. The District of Columbia Municipal Regulations Title 22, Public Health and Medicine, Chapter 13, Prescriptions and Distribution referenced within this chart may be found on pages 8-10 of this newsletter. Pull out this section and save for easy reference.

Please note: Federal and District regulations do not allow electronic "e"-prescribing of controlled substances.

PRESCRIBING CONTROLLED SUBSTANCES				
	Schedule II	**Schedule III**	**Schedule IV**	**Schedule V**
Is faxing a prescription allowed?	No.	Yes. Fax must provide phone number of origin. Must be faxed from physician's office. See DCMR Title 22, Chapter 13—Section 1303.6 for complete rules and regulations.	Yes. Fax must provide phone number of origin. Must be faxed from physician's office. See DCMR Title 22, Chapter 13—Section 1303.6 for complete rules and regulations.	Yes. Fax must provide phone number of origin. Must be faxed from physician's office. See DCMR Title 22, Chapter 13—Section 1303.6 for complete rules and regulations.
Do prescriptions expire if not filled at the pharmacy?	Valid 30 days only after written. May not be refilled.	Five (5) refills only; may not be refilled or extended beyond six (6) months from date issued.	Five (5) refills only; may not be refilled or extended beyond six (6) months from date issued.	Five (5) refills only; may not be refilled or extended beyond six (6) months from date issued.
Is there a maximum day's supply that can be written?	No.	No.	No.	No.
Is there a limitation on refills allowed?	Every prescription for a controlled substance listed in Schedule II shall not be refilled.	A prescription authorized to be refilled may not be refilled more than five (5) times within six (6) months. See DCMR Title 22, Chapter 13 —Section 1310.7 for complete rules and regulations.	A prescription authorized to be refilled may not be refilled more than five (5) times within six (6) months. See DCMR Title 22, Chapter 13 —Section 1310.7 for complete rules and regulations.	A prescription authorized to be refilled may not be refilled more than five (5) times within six (6) months. See DCMR Title 22, Chapter 13 —Section 1310.7 for complete rules and regulations.
Are telephone prescriptions allowed?	In emergency only. Within seventy-two (72) hours after authorizing an emergency oral prescription the prescribing individual practitioner shall have a written prescription for the emergency quantity presented delivered to the dispensing pharmacist.	Yes.	Yes.	Yes.

REGULATIONS FOR PRESCRIBING CONTROLLED SUBSTANCES

CODE OF D.C. MUNICIPAL REGULATIONS
TITLE 22. PUBLIC HEALTH AND MEDICINE
CHAPTER 13. PRESCRIPTIONS AND DISTRIBUTION
CDCR 22-1303 (2008)

22-1303. Telephone Facsimile Prescription Orders.

1303.1 A practitioner shall not transmit a prescription via telephone facsimile if in doing so it would interfere with a patient's freedom to choose a pharmacy, or without a patient's consent.

1303.2 A pharmacist shall not dispense a telephone facsimile prescription drug order for a controlled substance listed in Schedule II, except as permitted under § 1306 of this chapter.

1303.3 A telephone facsimile prescription shall be transmitted only by a practitioner or a practitioner's designated agent directly from the practitioner's office or a health care facility to the pharmacy with no intervening person having access to the prescription drug order.

1303.4 To maintain the confidentiality of patient records:

(a) The pharmacy and the practitioner shall both have adequate security and system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of patient records and telephone facsimile transmissions; and

(b) The pharmacy shall implement and maintain procedures, system controls and other efforts to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), federal and District laws regarding the confidentiality and protection of patient information.

1303.5 The pharmacy shall implement and maintain procedures to verify the authenticity of the telephone facsimile transmission and its source of origin which may include:

(a) Maintenance of a practitioner's telephone facsimile number reference;

(b) Verification of the telephone number of the originating telephone facsimile equipment; and

(c) Telephone verification with the practitioner's office that the prescription as transmitted via telephone facsimile contains the same exact information it contained when originated by the practitioner and contains no alterations by any intervening parties.

1303.6 In addition to conforming to all applicable federal and District requirements, a telephone facsimile prescription drug order shall contain the following at the time it is transmitted:

(a) A prescription bearing the following information:

(1) The printed or typed full name, address, telephone number and facsimile number of the practitioner;

(2) The signature of the practitioner;

(3) The date of issuance;

(4) The full name and address of the patient;

(5) The name and dosage of the drug, directions for use, quantity dispensed, and number of refills, when applicable; and

(6) A statement which indicates that the prescription was transmitted via telephone facsimile;

(b) Along with the prescription, the following information shall be transmitted:

(1) The name, address, and facsimile number of the pharmacy to which the prescription was transmitted;

(2) The date the prescription was transmitted via facsimile to the pharmacy, if the date is different from the date of issuance of the prescription;

(3) If transmitted by a designated agent, the full name of the designated agent; and

(4) A clearly legible statement that:

(A) The telephone facsimile transmission is intended only for the recipient to which it was addressed and contains information that is confidential;

(B) The recipient is prohibited from distribution or dissemination of the information contained in the transmission unless permitted by federal or District law; and

(C) If the recipient is not the intended recipient or the authorized agent of the intended recipient, the recipient should immediately notify the sender by telephone and return the original message to the sender.

1303.7 In addition to the requirements of § 1303.6, a prescription for a controlled substance, when authorized by law for dispensing, shall also include the following:

(a) The practitioner's federal Drug Enforcement Administration (DEA) registration number;

(b) The practitioner's District of Columbia Controlled Substances registration number, if applicable;

(c) Be signed by the practitioner in the same manner as the practitioner would sign a check or legal document (for example: J.H. Smith or John H. Smith); and

(d) Any other requirements under District or federal law.

1303.8 Any person who is exempted from registration under federal or District of Columbia statute shall include on all prescriptions for controlled substances issued by him or her the registration number of the hospital or other institution and the special internal code number assigned to him or her by the hospital or other institution as provided in the Act or this chapter, in lieu of the registration number of the practitioner required by this chapter.

1303.9 An official exempted from registration under federal or District of Columbia statue shall include on all prescriptions issued by that individual, his or her branch of service or agency (e.g., U.S. Army or Public Health Service) and the individual's service identification number, in lieu of the registration number of the practitioner required by this chapter.

CDCR 22-1303 (2008) (continued)

1303.10 The service identification number for a Public Health Service employee is his or her social security identification number or, if applicable, his or her National Provider Identifier (NPI) number. Each prescription shall have the name of the officer stamped or printed on it, as well as the signature of the officer.

1303.11 The dispensing pharmacist shall document the following information on each facsimile prescription order that has been dispensed:

(a) The name or initials of the pharmacist who performed the final verification; and

(b) Any change or alteration made to the prescription dispensed based on contact with the practitioner to show a clear audit trail. This shall include, but not be limited to, a change in quantity, directions, or number of refills.

1303.12 Authorization obtained from the practitioner to substitute a drug, shall be documented on the prescription order, except in the case of an institutional pharmacy which maintains readily retrievable, written, documented policies authorizing such substitution.

STATUTORY AUTHORITY: D.C. Code §§ 2-2008, -2019; 6-3703, -3706; 33-731, -1003, -1005, -1007, -1014; 7-731; 47- 2885.18.01(a)(3); 48-714(a), -901.01; Mayor's Orders 91-47, 92-45, 98-48, 98-88

History of Rules since Last Compilation by Agency, (August 1986): December 22, 2006 1303.1 to 1303.12 new at 53 DCR 10055 by the Department of Health

CDCR 22-1310 (2008)

22-1310. Refilling of Prescriptions Listed in Schedules III, IV or V.

1310.1 A prescription for a controlled substance listed in Schedule III or IV may not be filled or refilled more than six (6) months after the date on which the prescription was issued.

1310.2 A prescription authorized to be refilled may not be refilled more than five (5) times.

1310.3 Each refilling of a prescription shall be entered on the back of the prescription, or on another appropriate, uniformly maintained, readily retrievable record such as a patient profile. The following information must be retrievable by the prescription number:

(a) The name of the controlled substance, or the name and manufacturer of the drug if it is a substitute or generic drug for the drug actually prescribed or filled initially;

(b) The strength and dosage form of the controlled substance;

(c) The date of each refilling and the quantity dispensed;

(d) The identity or initials of the dispensing pharmacist for each refill; and

(e) The total number of refills for that prescription.

1310.4 Each refilling of a prescription shall state the amount dispensed.

1310.5 If the pharmacist merely initials and dates the back of the prescription, he or she shall be deemed to have dispensed a refill for the full face amount of the prescription.

1310.6 The prescribing practitioner may authorize additional refills of a Schedule III, IV or V prescription controlled substance on the original prescription or through an oral refill authorization transmitted to the pharmacist provided that the following conditions are met:

(a) The total quantity authorized, including the amount of the original prescription, does not exceed five (5) refills or extend beyond six (6) months from the date of issue of the original prescription;

(b) The pharmacist obtaining the oral authorization shall record the date, quantity of refill, and number of additional refills authorized, on the reverse of the original prescription and initial the prescription documenting that he or she received the authorization from the prescribing practitioner who issued the original prescription; and

(c) The quantity of each additional refill authorized is equal to or less than the quantity authorized for the initial filling of the original prescription.

1310.7 Additional quantities of prescription controlled substances listed in Schedule III, IV or V, beyond the five (5) refill, six (6) month limitation, shall only be authorized by a prescribing practitioner through the issuance of a new and separate prescription.

1310.8 As an alternative to the procedures provided under § 1310.3 of this chapter, an automated data processing system may be used for the storage and retrieval of refill information for prescription drug orders for controlled substances in Schedule III, IV, or V, subject to the conditions outlined under 21 CFR § 1306.22(b).

STATUTORY AUTHORITY: D.C. Code §§ 2-2008, -2019; 6-3703, -3706; 33-731, -1003, -1005, -1007, -1014; 7-731; 47- 2885.18.01(a)(3); 48-714(a), -901.01; Mayor's Orders 91-47, 92-45, 98-48, 98-88

History of Rules since Last Compilation by Agency, (August 1986): December 22, 2006 1310.3, 1310.6, 1310.7 amended, 1310.8 new at 53 DCR 10055 by the Department of Health

EDITOR'S NOTE: Sections 1300 to 1306, 1309, and 1316 were replaced in their entirety by rulemaking published at 53 DCR 10055, effective December 22, 2006.

REGULATIONS FOR PRESCRIBING CONTROLLED SUBSTANCES

CDCR 22-1306 (2008)

This regulation is not mentioned in the chart on page 5, but you may find useful to have on hand.

22-1306. Prescriptions for Controlled Substances Listed In Schedule II.

1306.1 Except as otherwise authorized in this section, a controlled substance listed in Schedule II, which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act, shall only be dispensed pursuant to a valid written prescription signed by the prescribing practitioner, unless otherwise authorized by federal law.

1306.2 A prescription for a controlled substance listed in Schedule II shall not be filled if submitted more than thirty (30) days after the date on which the prescription was issued.

1306.3 A prescription for a controlled substance listed in Schedule II shall not be refilled and shall be cancelled out by a line drawn through the entire prescription order, with the date dispensed and initials of the person that dispensed the drug.

1306.4 A prescription for a Schedule II controlled substance may be transmitted by the practitioner or the practitioner's agent to a pharmacy via telephone facsimile equipment, provided that the original written, signed prescription is presented to the pharmacist for review prior to issuance of the controlled substance to the patient or the patient's representative. The original prescription shall be maintained in accordance with the requirements of this chapter and as required under federal and District law.

1306.5 In emergency situations, as defined under § 1306.6 of this chapter, a pharmacist may dispense Schedule II drugs upon the oral prescription of a practitioner. The pharmacist shall comply with the following requirements as set forth in 21 CFR § 1306.11(d) and failure to do so may result in suspension or revocation of a pharmacy registration:

(a) The quantity prescribed and dispensed is limited to no more than a seven (7) day supply to treat the patient during the emergency period (dispensing beyond the emergency period shall be pursuant to a written prescription signed by the prescribing individual practitioner);

(b) The prescription shall be immediately reduced to writing by the pharmacist and shall contain all information required by District and federal law;

(c) If the prescribing practitioner is not known to the pharmacist, the pharmacist shall make a reasonable effort to determine that the oral authorization came from a registered practitioner, which may include a call back to the prescribing practitioner using the practitioner's phone number as listed in the telephone directory or other good faith efforts to insure the practitioner's identity; and

(d) Within seven (7) days after authorizing an emergency oral prescription, the practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of § 1301 of this chapter, the prescription shall:

(1) Have written on its face "Authorization for Emergency Dispensing," and the date of the oral order; and

(2) The written prescription shall be delivered to the pharmacist in person or by mail, but if delivered by mail, it must be postmarked within the seven (7) day period. Upon receipt, the dispensing pharmacist shall attach the written prescription to the oral emergency prescription which was previously reduced to writing. The pharmacist shall notify, in writing, the Director if the prescribing individual practitioner fails to deliver a written prescription to him or her. Failure of the pharmacist to notify the Director shall void the authority conferred by this section to dispense without a written prescription of a prescribing practitioner.

1306.6 As used in this section "emergency situation" means those situations in which the prescribing practitioner determines the following:

(a) That immediate administration of the controlled substance is necessary, for proper treatment of the intended ultimate user;

(b) That no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II; and

(c) That it is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance, prior to the dispensing.

1306.7 A prescription for a Schedule II controlled substance to be compounded for direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion may be transmitted by the practitioner or the practitioner's agent to the institutional or home health care pharmacy by telephone facsimile. The telephone facsimile shall serve as the original written prescription and shall be maintained in accordance with the requirements of this Title and federal and District law.

1306.8 A prescription for a Schedule II controlled substance for a resident of a Long Term Care Facility may be transmitted by the practitioner or the practitioner's agent to the dispensing pharmacy by telephone facsimile. The telephone facsimile shall serve as the original written prescription and shall be maintained in accordance with the requirements of this Title and federal and District law.

1306.9 A prescription for a Schedule II controlled substance for a patient enrolled in a hospice care program certified or paid for by Medicare under Title XVIII or a hospice program which is licensed by the District may be transmitted by the practitioner or the practitioner's agent to the dispensing pharmacy by telephone facsimile. The practitioner or the practitioner's agent shall note on the prescription that the patient is a hospice patient. The telephone facsimile shall serve as the original written prescription and shall be maintained in accordance with the requirement of this Title and federal and District law.

1306.10 An individual practitioner may administer or dispense directly to a patient a Schedule II controlled substance in the course of his or her professional practice without a prescription, subject to the conditions set forth in 21 CFR § 1306.07.

1306.11 An institutional practitioner may administer or dispense directly, (but not prescribe) a controlled substance listed in Schedule II only pursuant to:

(a) A valid written prescription signed by the prescribing individual practitioner; or

(b) An order for medication made by an individual practitioner which is dispensed for immediate administration to the patient, subject to § 21 CFR 1306.07.

STATUTORY AUTHORITY: D.C. Code §§ 2-2008, -2019; 6-3703, -3706; 33-731, -1003, -1005, -1007, -1014; 7-731; 47- 2885.18.01(a)(3); 48-714(a), -901.01; Mayor's Orders 91-47, 92-45, 98-48, 98-88

History of Rules since Last Compilation by Agency, (August 1986):

December 22, 2006 1306.1 to 1305.11 new at 53 DCR 10055 by the Department of Health

EDITOR'S NOTE: Sections 1300 to 1306, 1309, and 1316 were replaced in their entirety by rulemaking published at 53 DCR 10055, effective December 22, 2006.

MOST FREQUENT CAUSE OF COMPLAINTS AGAINST PHYSICIANS IN THE DISTRICT: COMMUNICATION ISSUES

A significant number of complaints that are received by the D.C. Board of Medicine can be attributed to poor communications skills. These complaints often include claims of:

- "rudeness"
- alleged failure to return telephone calls, or
- alleged failure to explain matters thoroughly to a patient or a patient's family.

Most of the communication complaints that the Board receives are not egregious and do not warrant formal disciplinary action, but they may have an impact on doctor-patient relationships. Communications problems can produce less-than-satisfied patients and ultimately can result in the deterioration of a medical practice.

There are several principles that promote good communications: candor, compassion, listening, and documentation.

CANDOR

The first principle is candor. Licensees should be completely honest with patients about medical matters. Communicating with candor regarding possible courses of treatment and possible outcomes is required.

COMPASSION

A second essential ingredient to good communication is compassion. In some cases, physicians have the unpleasant task of being the bearer of bad news. Physicians should strive to be as tactful as possible without sacrificing candor.

LISTENING

Communication should be a two-way street. Listening to patients' questions and addressing them fully is important. To ensure that patient issues have been addressed, a physician should consider ending a dialogue with the question: "Do you have any more questions?"

DOCUMENTATION

Documentation is also an important principle of good communication. Patient records should reflect what the physician discussed with the patient or the patient's family, and it might prove helpful to note the time spent on the discussion.

SUPERVISION OF OFFICE STAFF

Lastly, to ensure good communication, supervision of office staff is important. Many of the communications complaints that are received by the D.C. Board of Medicine are complaints about the physicians' office staff.

When a staff person has a sub-optimum communications experience, the physician should instruct the staffer how such matters should be handled in the future.

COMMUNICATION COMPLAINTS?

If a physician has received more than one communications-related complaint, then consideration should be given to remedial action in the form of CME courses designed to improve communication skills.

Good communication can improve the level of satisfaction with patient care.

TIPS FOR EXPEDITING YOUR LICENSE

- Make sure to have your entire application filled out and signed.
- Provide official court documents of final case dispositions for any felonies or misdemeanors that you incurred (i.e., a defendant in any state or country).
- Malpractice case dispositions should include a case number, jurisdiction, year, all the defendant names, all plaintiff names, a brief summary of the case, and final disposition, such as judgment dollar amount, dismissed with or without prejudice, or settlement dollar amount—this information must be sent with your application.

Verification of Licensure

Licensing authorities and some health facilities often require a letter of verification of the licenses you currently hold or have held in the past. These letters of verification are sometimes called "letters of good standing," even though your DC license may have expired.

If the jurisdiction or institution to which you wish the letter sent gave you a form, simply forward the form, with a check or money order payable to "DC Treasurer" in the amount of thirty-four dollars ($34.00) to:

DC Board of Medicine
Suite 600
717 14th Street, NW,
Washington, DC 20005

On the form, be sure to include your name and the address where the form is to be sent.

If the jurisdiction or institution to which you wish the letter sent did not give you a form, send the payment referenced above and a short note requesting a letter of verification. The note should include your name, and the name and address of where you want the letter of verification sent.

MEDICAL SPAS: THE NEW FRONTIER IN HEALTH REGULATION

By Lucy Panoyan, Bill Archer Fellow
Interning for the DC Board of Medicine

Currently, the DC Board of Medicine is weighing what rules might be needed to regulate certain procedures performed in what are commonly known as "medical spas." The practice of medicine in the area of cosmetic procedures has developed so quickly that the Board of Medicine thought this was an excellent time to determine if additional oversight was needed regarding any of the procedures most commonly practiced in medical spas.

The following information was presented to the Board at the February 27, 2008 meeting. The Board will revisit this subject at an upcoming meeting.

Questions for the Board to consider include:

1) Which procedures, if any, should be included under the definition of the practice of medicine?

2) If a procedure is encompassed under the definition, may the physician delegate the execution of the procedure to someone who is not a physician, and—if so—what should be the minimum level of supervision required by the physician and the minimum level of training required by the delegated individual?

Recently, there has been a technological boom in the cosmetic medicine industry and with it has been an increase in demand for medical spa procedures. "Medical spas," also known as "med spas" and "medi-spas," have found themselves in the center of the industry growth and are currently under scrutiny by medical boards across the nation. The National Coalition of Estheticians, Manufacturers/Distributors, & Associations (NCEA) defines a medical spa as:

A facility that during all hours of business shall operate under the on-site supervision of a licensed health care professional operating within the scope of his or her practice, with a staff that operates within their scope of practice as defined by their individual licensing board if licensure is required. The facility may offer traditional, complimentary, and alternative health practices and treatments in a spa-like setting.

Medical spas provide treatments such as laser hair removal, microdermabrasions, chemical peels, mesotherapy, sclerotherapy, radiofrequency procedures and injections such as Botox® and Restylane®. This list is by no means comprehensive and new procedures are constantly added to the list, giving consumers more options when choosing a medical spa treatment.

If medical spa treatments are regulated at all, it is by the state governments—and the range of regulation varies: some states currently do not regulate these procedures; some states regulate select procedures.

Laser Hair Removal

Laser hair removal, which is one of the most common medical spa treatments, is a procedure in which a laser is applied to the skin and subsequently absorbed by the pigment in the skin, permanently damaging the hair follicle. It is currently the most regulated of all the medical spa procedures and most states have a state regulation outlining who may do the procedure and to whom they can delegate the procedure.

Of the 50 states, 26 states have a regulation concerning the use of lasers for cosmetic procedures. Thirteen other states have a policy issued by their board of medicine that serves as a guideline for how the board views the appropriate use of lasers for hair removal. Seven states currently do not have any regulations and four states include the use of lasers in the definition of medicine, as defined in their state statutes.

Who May Perform Laser Treatment?

Who is allowed to perform laser hair removal and other medical spa treatments is currently the most disputed issue in medical spa regulation. Some experts have argued that only physicians and other health care professionals should be allowed to perform such procedures, while others maintain that as long as an individual is appropriately trained, they should be allowed to perform these procedures as well. The main concern over who should have the right to perform medical spa treatments is the potential danger of these procedures if delegated to the wrong hands.

In 2002, the American Society for Dermatologic Surgery conducted a survey that indicated a 41 percent increase in the need for treatments to reverse the damage done from skin treatments performed by non-physician

(continued on page 13)

"If medical spa treatments are regulated at all, it is by the state governments—and the range of regulation varies: some states currently do not regulate these procedures; some states regulate select procedures."

(continued from page 12)

technicians. Currently, 40 states have guidelines on the delegation of laser hair removal. Twenty-one of the states allow a physician to delegate laser hair removal to a licensed healthcare professional (such as a physician assistant, registered nurse or licensed practical nurse), while 17 states allow doctors to delegate to anyone who is appropriately trained. Two states have regulations that prevent anyone other than a licensed physician from performing laser hair removal.

Supervision

Another controversial issue concerning medical spa treatments is the level of supervision a physician must provide when the procedure is performed by a delegated individual. Of the 40 states that discuss delegation of laser hair removal, 34 states have rules on the physician supervision of the delegated individuals. Twenty-seven states require that the physician be "on-site" but not necessarily physically present during the procedure, while six of the states require the physician to be physically present. One of the states requires that a physician be available for emergencies on an "as needed" basis.

Other Procedures

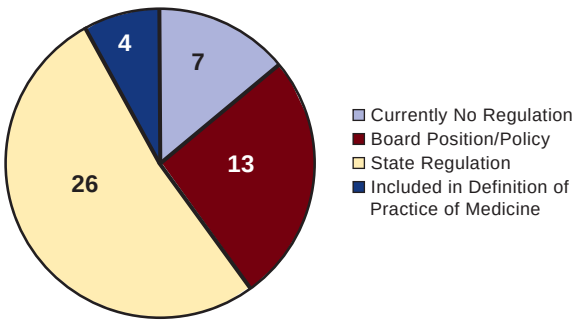
Although the majority of states currently have regulations on laser hair removals, other medical spa treatments are not as strictly regulated.

The District of Columbia Board of Medicine is currently in the process of clarifying regulations concerning medical spa treatments and will attend to questions such as:

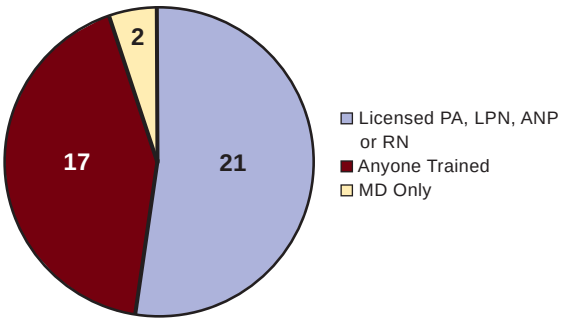
- Should certain medical spa treatments be included in the definition of practice of medicine?
- Who can perform these procedures determined to be the "practice of medicine?"
- To whom can these procedures be delegated?
- What kind of training should the individuals performing these procedures be required to possess?
- What should be the level of supervision?

When novel medical technologies emerge, questions such as these need to be resolved in order to ensure the public's safety.

Number of States with Laser Hair Removal Regulations



Number of States with Delegation Regulations*



SHARE YOUR VIEWS ON "MEDICAL SPAS"

Readers are invited to submit comments regarding medical spas to:

DC Board of Medicine
Attn: Executive Director
717 14th Street, NW, Suite 600
Washington, DC 20005

Physicians and members of the general public may also attend the public Board sessions which present issues (such as this one) for the Board to consider. At these open sessions, members of the public have the opportunity to address the Board on any topic involving the practice of medicine. The Board of Medicine meets the last Wednesday of each month.

Writer Lucy Panoyan is a senior Biology major at the University of Texas at San Antonio.

BOARD ORDERS

October 17, 2007 - March 6, 2008

Revoked

Dee, Rosita Hao (11/7/07) The physician's D.C. medical license was revoked as a result of a Maryland order of revocation on July 13, 2007 due to repeated quality of care issues. [Psychiatry & Neurology]

Kashif, Fahim (12/6/07) the physician assistant's D.C. license was revoked as a result of disciplinary action in Maryland and for fraudulently or deceptively obtaining a license in D.C.

Levitt, Keith N. (2/8/08) The physician's D.C. medical license was revoked as a result of disciplinary action in the State of Washington and Arizona on charges related to relapsed substance abuse. [Anesthesiology]

Denied

Shahzad, Saaed (12/14/07) The physician's application for a D.C. medical license was denied because he failed to pass all three parts of the USMLE examination within seven years as required by D.C. medical regulations. [Psychiatry & Neurology]

Summarily Suspended

Chigbue, Brian A. (1/25/08) The physician's D.C. medical license was summarily suspended effective 2/6/08 as a result of the summary suspension of his Maryland medical license for the assault of two patients. The physician was also arrested and indicted on charges of rape and assault. The physician's conduct represents an imminent danger to the citizens of the District of Columbia. [Internal Medicine]

Figueroa, Armando B. (11/14/07) The physician failed to conform to standards of acceptable conduct and prevailing practice in the practice of medicine, prescribed drugs when not authorized to do so, and wrote prescriptions for controlled substances and other drugs without putting a date of issuance on the prescription in violation of D.C. statutes. In view of the above, the physician's conduct was an imminent danger to the health and safety of the residents of the District of Columbia, and his D.C. medical license was summarily suspended. [Internal Medicine]

Pooya, Manoochehr (11/7/07) The physician was convicted in D.C. Superior Court on November 2, 2007 of sexual abuse involving his actions with a patient, and was served with a Notice of Summary Suspension on November 8, 2007 because his actions represent an imminent danger to the health and safety of the residents of the District of Columbia. [Internal Medicine]

Wolde-Tsadik, Seife Meshesha (1/18/08) The physician's D.C. medical license was summarily suspended as a result of the Virginia summary suspension of his medical license for substance abuse and prescription violations that represent an imminent danger to the citizens of the District of Columbia. [Internal Medicine]

Suspended

Allen, Laurence T. (11/1/07) The physician's D.C. medical license was suspended because he violated the February 5, 1997 Order of the D.C. Board of Medicine. [Psychiatry & Neurology]

Udebiuwa, Oparaugo I. (10/31/07) The physician pled guilty to five counts of Medicaid fraud in Maryland and his D.C. medical license was suspended for one year. [Psychiatry & Neurology]

Probation, Fined and Remediation

Williams, Cleveland (1/30/08) The physician's D.C. medical license was placed on probation for a minimum of one year. He was required to take an ethics course, have a psychiatric evaluation, continue in therapy as indicated, and fined as a result of surrendering his Nebraska license on or about July 28, 2006 for actions related to a mental health disorder. [Preventative Medicine/Public Health]

Probation and Reporting Requirements

Allen, Laurence T. (1/7/08) The physician's D.C. medical license was placed on probation for two years with reporting requirements and the suspension that was imposed November 1, 2007 for violating an order of the Board was lifted. [Psychiatry & Neurology]

Probation and Remediation

Kirk, Ian (1/29/08) The physician's D.C. medical license was placed on probation by consent order for at least one year and he was required to take an ethics course as a result of denial of his application for a Maryland medical license for making false statements on his application. [Anesthesiology]

Probation

Vaughn, William S. III (1/22/08) The physician's D.C. medical license was reinstated on probation from the May 16, 2006 Order of Revocation. [Emergency Medicine]

Fined

Dennis, Robert H. II (11/13/07) The physician was fined for failing to reply to an Order to Answer within ten days of receipt. [Plastic Surgery]

Probation Terminated

Mamodesene, Dora (2/7/08) The physician satisfied the terms of her probation. [Family Medicine]

Other

Memon, Zarina G. (3/6/08) The physician voluntarily agreed not to practice in the District of Columbia, pending resolution of licensure issues in the Commonwealth of Massachusetts. [Anesthesiology]

Malakoff, Gary (2/28/08) Practice restrictions lifted. The physician satisfied the Board that he is able to practice. [Internal Medicine]

FILING A COMPLAINT WITH THE BOARD OF MEDICINE

To file a complaint against a licensed DC physician or physician assistant, simply write a letter that describes your complaint. The letter must be signed, and you should attach copies of any pertinent documents that you may have. The letter must also include your address, so we may contact you as necessary and notify you of any findings.

You should mail the complaint to:

DC Board of Medicine
Suite 600
717 14th Street, NW
Washington, DC 20005

You can also fax the complaint to the Board at (202) 724-8677.

If your complaint alleges unlicensed activity, you should address your complaint to:

Supervisory Investigator
Suite 1000
717 14th Street, NW
Washington, DC 20005

You can also fax your complaint about unlicensed activity to (202) 724-8677.

PLEASE NOTE: You can print a complaint form from our website at www.hpla.doh.dc.gov

Please be advised that the health professional licensing boards do not have jurisdiction over fee disputes, except for billing for services that were not provided. If you have a fee dispute with a health professional, you can seek redress through the civil courts.

NEED INFORMATION ABOUT A DISTRICT PHYSICIAN?

Online profiles of District physicians are available for public viewing via the DC DOH web site at: http://hpla.doh.dc.gov/hpla/site/. Users can search the database by first name, last name, license number or status. The physician information available on our website is as follows:

Provided by the Board:

- Licensee name
- License number
- Date of issue
- Date of expiration
- Any DC Board of Medicine Notice or Order

No personal information such as Social Security number, home address or home telephone is displayed.

Provided by Physician:

- Practice information (location, telephone number, translating services, percentage of time spent at location(s)
- Education
- Years in active clinical practice
- Board Certifications
- Hospital affiliations
- Academic appointments
- Publications
- Medicaid participation
- Actions and Felony convictions
- Paid claims in the most recent ten years
- Insurance plans accepted or managed care plans in which he or she participates
- Hours of continuing education
- Subspecialties obtained
- Honors and awards received
- Practice name in the practice location
- Days of the week at practice location
- Medicare information
- Non-emergency email address

EACH PHYSICIAN IS REQUIRED TO UPDATE HIS OR HER PROFILE WITHIN 30 DAYS OF A CHANGE.

To update your profile, login to the system at: https://app.hpla.doh.dc.gov/mylicense/

If you do not remember your user name and password, or you have never created an on-line user name or password, follow the directions for "new users."

Questions? Call Antoinette Stokes at (202) 724-8799 or Alesia Henry at (202) 724-8797.

Need information, an application, or to verify a license?
Visit the Health Professional Licensing Administration 's webpage: www.hpla.doh.dc.gov

Government of the District of Columbia
Adrian M. Fenty, Mayor

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH

Health Professional
Licensing Administration

Address
DC Board of Medicine
717 14th Street, NW
Suite 600
Washington, DC 20005

Board phone number
(202) 724-8800

Fax number
(202) 724-8677

DC Government website
www.dc.gov

HPLA webpage
www.hpla.doh.dc.gov

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